Editorials

Health Care in a Dreamworld

THE REMARKABLE ACHIEVEMENTS of medical science and technology, and the social, economic and political responses to these achievements have produced a kind of dreamworld in health care. Depending upon one's point of view, the dreams may be good or bad. In any case, it is not nature's way to dream forever. It is reasonable to expect that someday there will be an awakening and it will be discovered that the dreams were never real, and that reality is something different.

The dreams are many. Some are the dreams of society as a whole, some are of health planners wherever they may be and some are of physicians, other health professionals or the medical profession itself. Most are all too familiar:

- A free market and profit incentives in health care will, over time, solve the problems of health care distribution and will lower costs.
- Competition will provide a better product at lower cost, as it has done in so many other aspects of American life.
- The excess numbers of physicians and other health care providers will meet, or more than meet, the needs for health care services in medically underserved areas.
- Medical science should, by now, achieve near perfection in health care or someone or something must be to blame.
- Medical science has now displaced the need to study and practice the traditional art in patient care.
- Prevention and health education will reduce health care costs because fewer people will get sick and everyone will live longer.

All these are fantasies, often heavily laced with wishful thinking. Yet it is beliefs such as these that seem to dominate a dreamworld of health care in which this nation now finds itself.

Then there are some really bad dreams. For some they may even seem like nightmares. Funding for the care of the poor, the disadvantaged and underprivileged is being more or less systematically reduced, with now measurable deterioration in the health status of many of them. Physicians are finding themselves no longer always in charge of patient care but nevertheless being held individually and collectively responsible for it in the minds of the public and in the courts of law. Medicare, Medicaid, DRGs, PROs, government regulations and the requirements of private sector payors in patient care all too often are producing costly administrative nightmares for physicians and hospitals and siphoning off dollars that might otherwise be used to provide needed care. And then there are conflicts among physicians and conflicts with hospital administrators and with other health professionals who may seek to occupy more and more of physicians' role and turf. The list of bad dreams, nightmares and potential nightmares could go on and on. As physicians know, the list these days is a long one.

But sooner or later there must come an awakening. It will never be profitable to provide care for those who cannot pay. There is accumulating evidence that the health of disadvantaged youth, particularly among the minorities, is worsening. The free market makes a travesty of anything like equity in health care. Medicine is not an exact science and never will be. It is also a fact that the longer more people live, the more health care they may be expected to consume, with the attendant greater costs. It is a reality that there will never be enough dollars to do everything we now know how to do for every patient. Yet at the same time dollars are being spent for frills, profit-making ventures and the like, rather than on genuinely needed health care. After all, health care is for people, not just for governments, corporations, investors or profiteers. Denied or deferred care is not likely to be cost effective for patients or for society.

What to do? Will this dreamworld go on forever? It is patently unrealistic and inefficient. As someone has said, health care has become a crazyquilt patchwork of ad hoc interventions, usually based on incorrect assumptions, that in general have created more problems than they have solved. As a result many of the solutions are now becoming the problems. Perhaps it is time to get back to some fundamentals such as,

- Recognize the important but actually limited role of medical science and technology in overall patient care.
- Study, define and perhaps even begin to measure what goes on in a clinical encounter between doctor and patient, and what it takes to give satisfaction to both.
- Address the social, economic and political issues that arise from medical progress, whether in individual patient care or elsewhere in the health care enterprise, and seek consensus among the interested parties about what to do and how to do it.

Conflicting interests abound in all of this, and in the real world of health care ways must be found to balance these various interests in what will always be dynamic and changing situations. In the meantime the dreams and the nightmares both run rampant in the professional and public consciousness, or perhaps one should say unconsciousness. In the meantime, much that is valuable in health care is being unnecessarily lost to patients and to society.

MSMW

Diagnosis and Treatment of Smell and Taste Disorders

THE DIAGNOSIS AND TREATMENT of chemosensory disorders have recently received more attention than in the past several years. This increased interest has focused both on the development of improved diagnostic tests and on a deeper understanding of the physiological mechanisms involved in the chemical senses.

Quantification of olfactory (or gustatory) deficits has been limited by the fact that the precise types of measurement needed to diagnose a disorder are not well understood. The tests commonly used to diagnose a general smell or taste loss include threshold and identification tasks. For threshold measurements, one can determine the concentration at which a stimulus is first detected (a detection threshold) or first recognized and labeled (a recognition threshold). Quantification of detection thresholds is straightforward while determination of recognition thresholds is not. The recognition problem lies in the fact that we do not have a standardized vocabulary to assign to most odors and tastants. Thus, at low concentrations when an odor such as lemon is first recognized, it may be